

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>15G266</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C 02/27/2012</b>	
NAME OF PROVIDER OR SUPPLIER  <b>TRANSITIONAL SERVICES SUB LLC</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>2840 JOHN ST NEW HARMONY, IN 47631</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{W 000}	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a post-certification revisit (PCR) survey to the PCR completed 12/2/11 to the investigation of complaint #IN00096235 completed on 10/20/11.</p> <p>This visit was in conjunction with the investigation of complaint #IN00103474 which resulted in an Immediate Jeopardy.</p> <p>Complaint #IN00096235-Corrected.</p> <p>Dates of Survey: 2/21, 2/22, 2/23, 2/24 and 2/27/12</p> <p>Facility Number: 000786 Provider Number: 15G266 Aim Number: 100248990</p> <p>Surveyor: Paula Chika, Medical Surveyor III-Team Leader</p> <p>Transitional Services Sub LLC was found to be in compliance with 42 CFR Part 483, Subpart I and 460 IAC 9 in regard to the PCR to the PCR to the investigation of complaint #IN00096235. Quality Review completed 3/2/12 by Ruth Shackelford, Medical Surveyor III.</p>			{W 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.